DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/24/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445237	A. BUILDING _____ B. WING _____	02/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHURCH HILL CARE & REHAB CTR	701 WEST MAIN BLVD CHURCH HILL, TN 37642

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F 000	INITIAL COMMENTS A recertification survey and investigation of complaints #38090, #38243, and #38294, were completed on February 23, 2016, at Church Hill Care and Rehab Center. No deficiencies were cited in relation to complaints (#38090 and #38294) under 42 CFR Part 483, Requirements for Long Term Care Facilities. AMENDED 3/10/16 to clarify resident number in F 318. AMENDED 3/24/16.	F 000	This Plan of Correction (POC) has been developed in compliance with State and Federal Regulation. This plan affirms that Church Hill Health and Rehabilitation's intent and allegation of compliance with those regulations. This POC does not constitute an admission or concession of either accuracy or factual allegation made in, or existence, or scope of significance, of any cited deficiency.	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as	F 157	F157 A. With respect to the Specific Residents Cited: Resident's physician and family were notified of an allegation of abuse for resident #107, #146, and #92 by the DON/ADON/ designee. Residents were assessed by the nurse at the time of the alleged abuse and no issues were identified. B. With Respect to How the Facility will Identify Residents with the Potential for the Identified Concern and Take Corrective Action: Residents have the potential to be affected by the deficient practice allegation of failure to follow facility standards regarding resident rights and allegations of abuse and neglect. An audit of residents' concerns regarding resident rights and abuse/neglect was done by Administrator and Regional Director Clinical Operations (RDCO) on	3/19/16

BORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Administrator — 03/17/2016

/ deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that
er safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days
)wing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14
s following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued
)gram participation.

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F 157	Continued From page 1 specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on facility policy review, medical record review, review of a facility investigation and interview, the facility failed to notify the Physician and families of an allegation of abuse in a timely manner for 3 residents (#107, #146 and #92) of 7 residents reviewed for abuse of 35 sampled residents. The findings included: Review of the facility policy Abuse Prevention Standard, revision date of 9/2015, revealed "...The administrative or nursing supervisor assumes responsibility for immediate notification of the Administrator and the Director of Nursing, by phone if necessary, and also notification of the appropriate department head/family/responsible party..." Medical record review revealed Resident #107 was admitted to the facility on 4/1/14 with a readmission date of 1/29/16 with diagnoses including Diabetes, Anemia, Heart Failure, Chronic Obstructive Pulmonary Disease, Major Depression, Panic Disorder, Presence of Cardiac Pacemaker, Atrial Fibrillation and Respiratory Failure.	F 157	2/22/16, any issue was properly documented and addressed per facility standards through the Grievance process and/or investigative process when allegation presented. Facility staff was re-educated on facility standards regarding resident rights and allegations of abuse, timely notification of physician and family, and resident rights by the Nurse Educator and DON on 2/20/16 through 2/22/16, including the ADON, SW, Unit Manager #2, CNAs, including CNA #3 and LPNs, including LPN #1. Licensed staff will be re-educated by the Nurse Educator/designee regarding the appropriate steps to be followed for reporting allegations of abuse, including notification of physician, family per facility policy by 03/16/16. C. With Respect to What Systemic Measures have been put in place to address the Stated Concern. Residents' rights and allegations of abuse/neglect will be addressed according to facility standards, including documentation of the concern and appropriate follow up and resolution. By 03/16/16, facility staff was re-educated by the Nurse Educator (NE) and/or designee on resident rights and abuse/neglect. Education included how to report concerns; a review of policy to address, investigate and resolve the concerns, and what to do if a concern is not addressed in a timely manner after it is reported. Newly hired staff receives	

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F 157	Continued From page 2 Review of a witness statement dated 2/1/16 at 4:40 PM, revealed Resident #107 had reported an allegation of abuse to the Assistant Director of Nursing (ADON) during an interview regarding another resident's allegation of abuse at the facility. Continued review revealed "...They [Certified Nursing Assistants] (CNA) stayed in there playing their games while I laid in my bowel movement...I have cologne, deodorant, & [and] hairspray + [plus] cold cream missing & [CNA's] would come in here + [and] help theirself to my stuff just like they were @ [at]home...One girl was taking my picture, while I was using the pot...I was angry..." Medical record review of a Physician Notification Progress Note dated 2/22/16 and timed 3:41 PM, revealed the facility notified the resident's physician about the resident's missing property (21 days later) "...Data:fyi [for your information] resident [Resident #107] has made allegation that 'someone has taken' some of her personal property...resident [stated] the alleged incident occurred 2-3 weeks ago..." Medical record review of a Social Services Note dated 2/23/16 and timed 8:40 AM, revealed the facility notified Resident #107's husband regarding the allegation of missing property and allegation of staff members taking pictures of her (22 days later) "... Data : Phone call with... [Resident #107's husband] regarding resident's reports of missing items and pictures being taken by staff Action: Informed him that items were being replaced and management was continuing to follow up on report of picture. He gave verbal understanding and didn't express any concerns at this time..."	F 157	education on resident rights and abuse/neglect during the orientation process and at least annually. The DON/designee will conduct daily audits by reviewing the 24 hour report and any Grievance/Concern in to the Morning Meeting using the audit tool, "QAPI Daily Focused Rounds Form" to document any issues and then initiate actions required to ensure the deficient practice does not reoccur. Audits will be conducted daily for four weeks, then three times a week for four weeks, then weekly for four weeks, then randomly thereafter. **D. With Respect to How the Plan of Corrective Measures will be monitored:** Resident grievances, concerns or any allegations of abuse/neglect are immediately reported to a supervisor and documented by staff receiving the allegation and then those allegations are monitored and discussed Monday through Friday in the morning meeting by the facility Administrator (ADM) Social Services Director and DON. The Weekend Manager on Duty and/or Charge Nurse will immediately report any allegation of abuse reported on the weekend to the DON/designee and Administrator for timely investigation and reporting to occur. Concerns are immediately reviewed by the Administrator for appropriate corrective actions. The DON/designee reviews the	

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F 157	Continued From page 3 Medical record review of a Physician Notification Progress Note dated 2/23/16 and timed 9:11 AM revealed the facility notified Resident #107's physician regarding the resident's allegation of abuse (22 days later) "...resident alleges that someone 'took pictures' of her while she was in her room..." Interview with the Social Service Director on 2/23/16 at 9:38 AM, in the Social Service office, confirmed the Social Service Director was informed by the Administrator on 2/23/16 to call and notify Resident #107's family of the allegation of abuse. Interview with the Administrator on 2/23/16 at 10:00 AM, in the Administrator office, confirmed the facility had interviewed resident #107 and were aware of the allegations of abuse on 2/1/16. Continued interview, confirmed the facility failed to notify the resident's family and physician in a timely matter. Medical record review revealed Resident #146 was admitted to the facility on 2/4/16 with diagnoses including Difficulty in Walking, Muscle Weakness, Altered Mental Status, Dementia without Behavioral Disturbance, and Diabetes Mellitus Type 2. Medical record review of a Physician Notification note dated 2/23/16 and timed 9:14 AM revealed, "...resident alleges that staff was 'rough' with her in the shower room and 'threw' her up against the wall incident allegedly occurred approximately 3-4 weeks ago..." Review of a facility investigation dated 2/1/16	F 157	concern to determine if they have been properly documented and investigated and if it needs to be reported per state and facility standards. The ADM/DON is responsible for reporting any incident that fits the state protocol for reporting to the state agency. The ADM/DON also report the results of the incidents/investigations review to the Quality Assurance Performance Improvement (QAPI) Committee made up of the Medical Director, rehab manager, social services director, dietary/registered dietician, activities director, DON, ADON, unit managers from nursing, resident financial coordinator, restorative nurse, medical records director, or designated subcommittee. QAPI meetings occur monthly. The facility Administrator will chair the QAPI committee. Any aberrancy reported has interventions developed and appropriate actions taken by the ADM/DON in conjunction with the QAPI Committee. This includes but is not limited to in-services for the appropriate staff, a review of facility standards that relate to the aberrant practice, tracking/trending of concerns to identify root cause factors and implement preventive interventions and ongoing monitoring to assure the deficient practice does not recur. The ADM/DON in conjunction with the QAPI committee also reviews facility standards that relate to the aberrant practice and completes ongoing monitoring to assure the deficient practice does not recur. When current	

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F 157	Continued From page 4 revealed the facility initiated an investigation related to an allegation of abuse by Resident #146 "...resident reported to CNA, in shower room, that other CNAs were too loud & rough with her. Dept [Department Manager] on duty spoke with resident and resident stated that two staff are rude and tell her she can't talk to others. States won't take her to the bathroom...took her to bathroom and scraped her arm..." Continued review revealed, "...9. Was the resident's physician notified...not necessary or feasible...10. Were there other notifications...family...not necessary or feasible..." Interview with the Administrator on 2/23/16 at 3:42 PM, in the Administrator's office, confirmed the facility failed to notify Resident #146's physician of the abuse allegation until 2/23/16 (22 days later). Continued interview confirmed the facility had failed to notify the resident's family of the allegation of abuse. Medical record review revealed Resident #92 was admitted to the facility on 11/6/13, with diagnoses including Dementia, Cerebral Artery Occlusion with Infarct, Anxiety, Seizures, Depressive Disorder, and Dysphagia. Record review of the facility investigation incident report dated 2/18/16, revealed on 2/7/16, CNA #3 was feeding Resident #92 her breakfast and Licensed Practical Nurse (LPN) #1 was present in the room. Continued review revealed Resident #92's daughter was standing outside of the resident's room listening to what CNA #3 was saying to her mother. Continued review revealed both LPN #1 and the daughter heard Resident #92 tell CNA #3 "no" when offered another bite of food but CNA #3 continued to spoon food into the	F 157	interventions are not producing the desired outcome or resolution to prior issues, the ADM/DON in conjunction with the QAPI committee develop alternate interventions including employee training programs, employee competency testing for compliance, until the desired outcome is achieved, that all incidents are investigated thoroughly and reported to the state agency per facility standards/state requirements.	

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F 157	Continued From page 5 resident's mouth. Continued review revealed the LPN observed the incident and did not attempt to stop the CNA, from continuing to feed Resident #92. Interview with Registered Nurse Unit Manager #2 on 2/22/16, at 4:50 PM, in the conference room, confirmed the occurrence happened on 2/7/16, was reported to the Administrator on 2/8/16, and the resident's Physician was not notified until 2/10/16, when he was in house making rounds.	F 157		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must	F 225	F225 A. With respect to the Specific Residents Cited: Resident #107's allegation of abuse was investigated and reported to the Dept. of Health, on 2/19/16 by the Administrator. Facility staff conducted an investigation regarding resident #107's reports of missing personal items and findings resulted in reimbursement of missing items and concluded the investigation on 2/26/16. The allegation of abuse was unsubstantiated and final report sent to the Dept. of Health on 3/3/16. Resident #146's allegation of abuse was also investigated by the Administrator and ADON and found unsubstantiated and reported to the surveyor on the day of the survey 2/16/16 by the Admin. B. With Respect to How the Facility will Identify Residents with the Potential for the Identified Concern and Take Corrective Action:	3/19/16

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F 225	Continued From page 6 prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on facility policy review, facility investigation review, medical record review, and interview, the facility failed to initiate an abuse investigation for 1 Resident (#107) and failed to report an allegation of abuse to the State Survey Agency for 1 resident (#148) of 7 residents reviewed for abuse of 35 sampled residents. The findings included: Review of the facility policy, Abuse Prevention Standard, revision date 9/15, revealed "...All alleged violations involving mistreatment, abuse, or neglect will be thoroughly investigated by the facility under the direction of the Administrator and in accordance with state and federal law...An immediate investigation into the alleged incident, during the shift if [it] occurred on, is initiated as follows: Follow up and investigation results are completed... policy time zone and by appropriate personnel...IMMEDIATE RESPONSE: An incident report is to be completed, to include the written summary of the investigation and facility actions taken..."	F 225	Residents have the potential to be affected by the deficient practice allegation of failure to follow facility standards regarding reporting allegations of abuse and neglect. An audit of residents' concerns regarding resident rights and abuse/neglect was done by the Administrator and RDCO on 2/22/16, any issue was properly documented and addressed per facility policy through proper documentation on the Grievance Log and/or documented investigative process when allegation presented. A review of Fast Alert Reports, Resident Concerns Forms and the Grievance Log was performed by the Administrator and RDCO on 2/22/16 to check for any allegations or concerns that should have been investigated and/or reported. No other issues were identified. The DON/ADON and ADM were re-educated on investigating and reporting allegations of abuse/neglect by the Regional Director of Clinical Operations (RDCO) on 2/22/16. Department Managers, including the Central Supply Director and ADON were re-educated regarding abuse investigations and reporting allegations of abuse/neglect on the day of the survey 2/22/16 by the Nurse Educator. Facility staff including CNAs, including CNA#6, and LPNs, including LPN#2 was re-educated on facility policies on resident rights and allegations of abuse, timely notification of physician and family, and resident rights the Nurse Educator and DON on 2/20/16 through 2/22/16. Licensed staff will be re-educated by the Nurse	

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F 225	Continued From page 7 Medical record review revealed Resident #107 was admitted to the facility on 4/1/14 with a readmission date of 1/29/16 with diagnoses including Diabetes, Anemia, Heart Failure, Chronic Obstructive Pulmonary Disease, Major Depression, Panic Disorder, Presence of Cardiac Pacemaker, Atrial Fibrillation and Respiratory Failure. Review of a witness statement dated 2/1/16 at 4:40 PM, revealed Resident #107 had reported an allegation of abuse to the Assistant Director of Nursing (ADON) during an interview regarding another resident's allegation of abuse at the facility. Continued review revealed "...They [Certified Nursing Assistants] [CNA] stayed in there playing their games while I laid in my bowel movement...I have cologne, deodorant, & [and] hairspray + [and] cold cream missing & [CNA's] would come in here + help theirself to my stuff just like they were @ [at]home...One girl was taking my picture, while I was using the pot...I was angry..." Review of a facility investigation dated 2/19/16 revealed the facility initiated an investigation of Resident #107's allegegation of abuse on 2/19/16 (18 days later). Interview with the Administrator on 2/23/16 at 10:00 AM, in the Administrator's office, confirmed the facility had interviewed Resident #107 and were aware of the allegations of abuse on 2/1/16. Continued interview revealed the facility failed to initiate an investigation into the allegation of abuse until 2/19/16. Medical record review revealed Resident #146	F 225	Educator/designee regarding the appropriate steps to be followed for reporting allegations of abuse, including notification of physician, family per facility policy by 03/16/16. By 03/16/16, facility staff was re-educated by the Nurse Educator (NE) and/or designee on resident rights and abuse/neglect. **C. With Respect to What Systemic Measures have been put in place to address the Stated Concern.** Allegations of abuse/neglect will be addressed according to facility standards, including investigation and proper documentation of allegations of abuse/neglect, reporting and appropriate follow up and resolution. The DON/ADON and ADM were re-educated on investigating and reporting allegations of abuse/neglect by the Regional Director of Clinical Operations (RDCO) on 2/22/16. Department Managers, including the Central Supply Director and ADON were re-educated regarding abuse investigations and reporting allegations of abuse/neglect on the day of the survey 2/22/16 by the Nurse Educator. Facility staff including CNAs and LPNs was re-educated on facility policies on resident rights and allegations of abuse, timely notification of physician and family, and resident rights the Nurse Educator and DON on 2/20/16 through 2/22/16. Licensed staff will be re-educated by the Nurse Educator/designee regarding the appropriate steps to be followed for reporting allegations of abuse, including	

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F 225	Continued From page 8 was admitted to the facility on 2/4/15 with diagnoses including Difficulty in Walking, Muscle Weakness, Altered Mental Status, Dementia without Behavioral Disturbance, and Diabetes Mellitus Type 2. Review of facility policy Abuse Prevention Standard, last revised September 2015, revealed, "...Any complaint, allegation, observation or suspicion of resident abuse...is to be thoroughly reported..." Continued review revealed, "...as soon as the facility is aware of a situation that meets the reporting requirements, they must immediately notify the administrator, and other officials...Reporting is not expected to take 24 hours..." Review of a facility investigation dated 2/1/16 revealed the facility initiated an investigation related to an allegation of abuse by resident #146 "...resident reported to CNA, in shower room, that other CNAs were too loud & rough with her. Dept [Department Manager] on duty spoke with resident and resident stated that two staff are rude and tell her she can't talk to others. States won't take her to the bathroom...took her to bathroom and scraped her arm..." Review of a Witness Statement Report dated 2/1/16 and timed 12:24 PM, and signed by the ADON, revealed the facility interviewed Resident #146 regarding the abuse allegation. Continued review revealed the resident reported, "...Threw me into the shower chair and knocked the pee out of me..." Interview with the Administrator on 2/18/16 at 2:47 PM, in the Administrator's office, revealed the Administrator initiated the investigation of	F 225	notification of physician, family per facility policy by 03/16/16. By 03/16/16, facility staff was re-educated by the Nurse Educator (NE) and/or designee on resident rights and abuse/neglect. Education included how to report concerns; a review of policy to address, investigate and resolve the concerns, what to do if a concern is not addressed in a timely manner after it is reported. Newly hired staff receives abuse investigations and reporting allegations of abuse/neglect, timely notification of physician and family, and resident rights education during the orientation process and at least annually. applied the hemorrhoid cream received a disciplinary action by the ADON on 10/30/15 when he returned from suspension and The DON/designee will conduct daily audits by reviewing the 24 hour report and any Grievance/Concern in to the Morning Meeting designee using the audit tool, "QAPI Daily Focused Rounds Form" to document any issues and then initiate actions required to ensure the deficient practice does not reoccur. Audits will be conducted daily for four weeks, then three times a week for four weeks, then weekly for four weeks, then randomly thereafter. **D. With Respect to How the Plan of Corrective Measures will be monitored:** Allegations of abuse/neglect are immediately reported to a supervisor and documented by staff receiving the	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445237	A. BUILDING _____ B. WING _____	02/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHURCH HILL CARE & REHAB CTR	701 WEST MAIN BLVD CHURCH HILL, TN 37642

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F 225	Continued From page 9 Resident #146's allegation of abuse on 2/1/16. Interview with Licensed Practical Nurse (LPN) #2 on 2/19/16 at 2:45 PM, at the D-wing Nurse Station, revealed CNA #6 had reported to LPN #2 on 1/30/16 an allegation of abuse reported by Resident #146. Continued interview revealed CNA #6 reported to the LPN "...they were rough with her...threw her into the shower chair..." Continued interview revealed LPN #2 then reported the allegation of abuse to the manager on duty immediately. Interview with the Central Supply Manager [Manager on Duty] on 2/19/16 at 2:55 PM, in the conference room, revealed LPN #2 had reported the allegation of abuse made by resident #146 to the Central Supply Manager between 8:30 AM and 9:00 AM on 1/30/16. Continued interview revealed the Central Supply Manager was told that 3 employees were alleged to have been hugging and kissing in the resident's room and had "...put [Resident #146] too hard on shower chair..." Continued interview revealed the Central Supply Manager then went to interview resident #146 and the resident told the Central Supply Manager "...told me put too hard on shower chair and made [resident] pee..." Further interview revealed the Central Supply Manager contacted the ADON and reported the allegation of abuse to her at approximately 10:00 AM on 1/30/16. Interview with the Administrator on 2/22/16 at 11:00 AM, in the conference room, confirmed the facility failed to report the allegation of abuse to the State Survey Agency.	F 225	allegation and then those allegations are monitored and discussed Monday through Friday in the morning meeting by the facility Administrator (ADM) Social Services Director and DON. Concerns reported on a weekend are immediately reviewed by the ADM/DON for appropriate corrective actions. The DON/designee reviews the concern to determine if they have been properly documented and investigated and if it needs to be reported per state and facility standards. The ADM/DON is responsible for reporting any incident that fits the state protocol for reporting to the state agency. The ADM/DON also report the results of the Incidents/Investigations review to the Quality Assurance Performance Improvement (QAPI) Committee Necessary interventions are developed and appropriate actions taken by the ADM/DON in conjunction with the QAPI Committee. When current interventions are not producing the desired outcome or resolution to prior issues, the ADM/DON in conjunction with the QAPI committee will develop alternate interventions until compliance is achieved.	
F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES	F 226		

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F 226	Continued From page 10 The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on review of facility policy, medical record review, review of facility staffing, review of facility documentation, and interview, the facility failed to suspend facility staff during a facility investigation of an allegation of abuse for 3 residents (#146, #70, #92) of 7 residents reviewed for abuse, of 35 sampled residents. The findings included: Review of facility policy Abuse Prevention Standard, revised September 2015, revealed, "...Investigation...all alleged violations involving mistreatment, abuse or neglect will be thoroughly investigated by the facility under the direction of the Administrator..." Continued review revealed, "...Immediate Response...2. Any employee suspected (alleged) of abuse will be suspended as the incident is reported; pending outcome of the investigation..." Medical record review revealed Resident #146 was admitted to the facility on 2/4/15 with diagnoses including Difficulty in Walking, Muscle Weakness, Altered Mental Status, Dementia without Behavioral Disturbance, and Diabetes Mellitus Type 2. Medical record review of an annual Minimum	F 226	F226 A. With respect to the Specific Residents Cited: Resident #146's event was reported 1/30/16 when the alleged staff members were scheduled off. This allegation was investigated and unsubstantiated by the Administrator and ADON. Resident #146 was assessed by the nurse on 1/30/16 with no reported injuries noted. The event for resident #70 was reported to a surveyor by a visitor, whom reported the event occurred around November, 2015. Upon notification of the report by the surveyor, the staff member alleged to have committed verbal abuse was suspended on 2/19/16 pending outcome of the investigation. This allegation was investigated during the survey, found unsubstantiated and reported to the Dept. of Health on 2/19/16. Resident #70 was assessed by the nurse and IDT during the month of November with no changes noted from baseline. Resident #70 is also seen by Psychiatric Consult, and has no reported ill effects from alleged event. For the event for resident #92, the employee involved was suspended on 2/8/16. Resident #92 was assessed by the nurse on 2/7/16 with no injuries noted. This allegation was substantiated and the employee terminated upon completion of the investigation. The results of the investigation were reported to the Dept. of Health initially on 2/8/16 and	3/19/16

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F 226	Continued From page 11 Data Set (MDS) dated 2/1/16 revealed the resident scored a 13 on the Brief Interview for Mental Status (BIMS) indicating the resident was cognitively intact. Continued review revealed the resident required the extensive assist of two staff for transfers and was totally dependent with the assist of one staff person for bathing. Review of a facility investigation dated 2/1/16 revealed the facility initiated an investigation related to an allegation of abuse by resident #146 "...resident reported to CNA [Certified Nurse Assistant], in shower room, that other CNAs were too loud & [and] rough with her. Dept [Department Manager] on duty spoke with resident and resident stated that two staff are rude and tell her she can't talk to others. States won't take her to the bathroom...took her to bathroom and scraped her arm..." Review of the Monthly Staff Schedule for February 2016 revealed CNAs #7 and #8 were scheduled to work on 2/1/16 from 5:00 AM to 2:00 PM on the A-wing hall of the facility (the wing Resident #146 resided). Review of a daily staffing assignment sheet for 2/1/16 revealed CNA #7 was assigned to work the C-wing of the building starting at 7:00 AM. Continued review of the daily staffing assignment sheet revealed CNA #8 was assigned to work the D-wing of the building starting at 7:00 AM. Further review revealed, "...These assignments are not to be changed per ADON [Assistant Director of Nursing] for the day..." Review of CNA #7's time punch detail for 2/1/16 revealed the CNA clocked in for work at 5:59 AM and worked until 6:02 PM. Continued review	F 226	followed up on 2/16/16 with final outcome. **B. With Respect to How the Facility will Identify Residents with the Potential for the Identified Concern and Take Corrective Action:** Residents have the potential to be affected by the deficient practice allegation of failure to follow facility standards regarding suspending employees involved in abuse and neglect allegations. An audit of residents' concerns regarding resident rights and abuse/neglect was done by the Admin. and RDCO on 2/22/16, and no issue regarding if employee suspensions were initiated as required per facility standards and no other issues were identified. A review of Fast Alert Reports, Resident Concerns Forms and the Grievance Log was performed by the Admin. and RDCO on 2/22/16 to check for any allegations or concerns that should have been investigated and/or reported or if employee suspensions were required. No other issues were identified. **C. With Respect to What Systemic Measures have been put in place to address the Stated Concern.** Allegations of abuse/neglect will be immediately addressed by DON/ADON/Admin upon receipt of allegation according to facility standards, including immediate suspensions as necessary, investigation	

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F 226	Continued From page 12 revealed CNA #7 was clocked out of work from 10:38 AM until 11:08 AM, and 3:30 PM until 4:00 PM. Review of CNA #8's time punch detail for 2/1/16 revealed CNA #8 clocked in for work at 7:03 AM and clocked out of work at 3:00 PM. Continued review revealed the CNA was clocked out of work from 10:35 AM until 11:04 AM. Interview with Licensed Practical Nurse (LPN) #2 on 2/19/16 at 2:45 PM, at the D-wing nurse station, revealed CNA #6 had reported to the LPN an allegation of abuse, which was told to CNA #6 by Resident #146. Continued interview revealed CNA #6 reported to the LPN Resident #146 told her two employees (CNA #7, CNA #8) had "...threw her [Resident #146] into shower chair..." Continued interview revealed the two named CNAs were not working that weekend (1/30/16 and 1/31/16). Further interview revealed the LPN then reported the allegation of abuse to the manager on duty. Interview with Central Supply Manager [Manager on Duty] on 2/19/16 at 2:55 PM, in the conference room, confirmed she was the manager on duty the weekend of 1/30/16 and 1/31/16. Continued interview revealed LPN #2 had reported to her the allegation of abuse made by Resident #146 on 1/30/16 between 8:30 AM and 9:00 AM. Further interview revealed the Central Supply Manager then interviewed Resident #146 and confirmed the resident reported the staff members (CNA #7, CNA #8) had placed the resident on the shower chair "...[resident] told me put too hard on shower chair and made me pee..." Further interview with the Central Supply Manager [Manager on Duty] confirmed the the Central Supply Manager then	F 226	and proper documentation of allegations of abuse/neglect, reporting and appropriate follow up and resolution. The DON/ADON and ADM were re-educated on investigating and reporting allegations of abuse/neglect by the Regional Director of Clinical Operations (RDCO) on 2/22/16. Department Managers were re-educated regarding abuse investigations and reporting allegations of abuse/neglect on the day of the survey 2/22/16 by the Nurse Educator. Facility staff, including CNAs, including CNA#3, #4, #6, #7, #8, and #10Central Supply Director, LPNs, including LPN#1 and #2, and RNs was re-educated on facility policies on resident rights and allegations of abuse, timely notification of physician and family, and resident rights the Nurse Educator and DON on 2/20/16 through 2/22/16. Licensed staff will be re-educated by the Nurse Educator/designee regarding the appropriate steps to be followed for reporting allegations of abuse, including notification of physician, family per facility policy by 03/16/16. By 03/16/16, facility staff was in-serviced by the Nurse Educator (NE) and/or designee on resident rights and abuse/neglect. Education included how to report concerns; a review of policy to address, investigate and resolve the concerns, what to do if a concern is not addressed in a timely manner after it is reported. Newly hired staff receives this education during the orientation process and at least annually.	

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F 226	Continued From page 13 contacted the Assistant Director of Nurses (ADON) on 1/30/16 at approximately 10:00 AM and reported Resident #146's allegation of abuse. Interview with the ADON on 2/19/16 at 9:40 AM, in the conference room, confirmed the ADON was notified of the allegation of abuse over the weekend [was unsure of the date]. Continued interview revealed the ADON called the Central Supply Manager [unsure of the date] over the weekend, and had the Central Supply Manager change the wing assignments for the two named CNAs (#7, #8) from their regularly scheduled assignments on A-Wing to the C and D-wings. Further interview confirmed the ADON contacted the Administrator over the weekend [unsure of date] and the Administrator was aware of the abuse allegation. Continued interview confirmed the ADON did not suspend the named CNAs during the course of the abuse investigation. Interview with the Administrator and ADON on 2/22/16 at 11:00 AM, in the conference room, confirmed neither the Administrator or ADON suspended the named CNAs (#7, #8) while the allegation of abuse was being investigated. Medical record review revealed Resident #70 was admitted to the facility on 11/6/13 with diagnoses including Anemia, Pressure Ulcer, Parkinson's Disease, Major Depressive Disorder, and Diabetes Mellitus Type 2. Review of a facility investigation dated 2/17/16 revealed, "...received complaint that CNA [CNA #10]...had yelled @ resident, telling him to shut-up..." Continued review of the investigation revealed the facility was aware of the name of the CNA who was alleged to have yelled at resident	F 226	The DON/designee will conduct daily audits by reviewing the 24 hour report and any Grievance/Concern in to the Morning Meeting designee using the audit tool, "QAPI Daily Focused Rounds Form" to document any issues and then initiate actions required to ensure the deficient practice does not reoccur. Audits will be conducted daily for four weeks, then three times a week for four weeks, then weekly for four weeks, then randomly thereafter. D. With Respect to How the Plan of Corrective Measures will be monitored: Allegations of abuse/neglect are immediately reported to the supervisor and documented by staff receiving the allegation and then those allegations are monitored and discussed Monday through Friday in the morning meeting by the facility Administrator (ADM) Social Services Director and DON. Concerns reported on a weekend are immediately reviewed by the ADM/DON for appropriate corrective actions. The DON/designee reviews the concern to determine if they have been properly documented and investigated and if it needs to be reported per state and facility standards. The ADM/DON is responsible for reporting any incident that fits the state protocol for reporting to the state agency. The ADM/DON also report the results of the incidents/investigations review to the Quality Assurance Performance	

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F 226	Continued From page 14 #70. Continued review of the investigation revealed, "...employee suspended pending investigation 2/19/16..." Review of time punch detail for CNA #10 revealed the CNA clocked in to work on 2/17/16 at 11:53 AM and worked until 6:10 PM with a lunch break from 3:40 PM to 4:10 PM. Continued review revealed the CNA clocked into work on 2/18/16 at 5:56 AM and worked until 6:11 PM with a lunch break from 10:50 AM until 11:20 AM and from 3:45 PM until 4:13 PM. Further review revealed the CNA worked in the facility on 2/19/16 from 5:57 AM until 9:57 AM. Continued review revealed the resident was suspended from work 2/19/16 at 10:00 AM. Interview with the Administrator on 2/23/16 at 10:53 AM, in the Administrator's office, confirmed the facility failed to suspend the named CNA immediately when became aware of the abuse allegation, and confirmed the CNA continued to work in the facility while the abuse investigation was ongoing. Medical record review revealed Resident #92 was admitted to the facility on 11/5/13, with diagnoses including Dementia, Anxiety, Seizures, Depressive Disorder, and Dysphagia (difficulty swallowing). Medical record review of the quarterly Minimum Data Set dated 1/24/16, revealed Resident #92 had a Brief Interview of Mental Status (BIMS) score of 2 indicating the resident was severely cognitively impaired and required the total assistance of staff members for all activities of daily living.	F 226	Improvement (QAPI) Committee Necessary interventions are developed and appropriate actions taken by the ADM/DON in conjunction with the QAPI Committee. When current interventions are not producing the desired outcome or resolution to prior issues, the ADM/DON in conjunction with the QAPI committee will develop alternate interventions until compliance is achieved.	

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F 226	Continued From page 15 Review of a facility investigation incident report dated 2/16/16, revealed on 2/7/16, CNA #3 was feeding Resident #92 her breakfast and LPN #1 was present in the room. Continued review of the facility investigation revealed Resident #92's daughter was standing outside of the resident's room listening to what CNA #3 was saying to her mother. Continued review of the investigation revealed both LPN #1 and the daughter heard Resident #92 tell CNA #3 "no" when offered another bite of food but CNA #3 continued to spoon food into the resident's mouth. Continued review revealed LPN #1 observed the incident. Interview with RN #2 on 2/19/16, at 12:10 PM, near the 300/400 nurse's desk, revealed when LPN #1 called her on 2/7/16, she reported that CNA #3 and CNA #4 were not getting along and she wanted CNA #3 off her unit now. Continued interview with RN #2 revealed LPN #1 had reported to RN #2, Resident #92's daughter had complained about how CNA #3 fed her mother. Further interview confirmed CNA #3 worked the remainder of her shift that day assisting residents. Interview with the Administrator and the ADON on 2/19/16, at 4:20 PM, in the Administrator's office, revealed the Administrator was unaware of the allegations of CNA #3 force feeding Resident #92 until she arrived at work on 2/8/16. Continued interview with the ADON revealed RN #2 called the ADON on 2/7/16 and stated that CNA #3 and CNA #4 were arguing about their assignments and that RN #2 moved CNA #3 to another unit. Continued interview revealed CNA #3 was allowed to finish her shift working with residents on 2/7/16, and was scheduled off on 2/8/16. Continued interview revealed the Administrator	F 226		

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F 226	Continued From page 16 and the Human Resources Manager called CNA #3, on 2/9/16, via conference telephone call and terminated her.	F 226		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on review of the facility Job Code for Certified Nursing Assistants (CNA) medical record review, review of personnel files, review of facility investigation and interview, the facility failed to provide services by a qualified person for 1 resident (#88) and the facility failed to implement the care plan for 1 resident (#92) of 35 sampled residents. The findings included: Review of the Job Code for Certified Nursing Assistant (CNA) dated 2/2/16, revealed CNAs did not have a duty or responsibility to administer medications. Medical record review revealed Resident #88 was admitted to facility on 7/2/13, with diagnoses including Muscle Weakness, Pneumonia, Osteoarthrosis, Anxiety, Depressive Disorder, Diabetes Mellitus, Diverticulosis, Symbolic Dysfunction, Difficulty walking, Atrial Fibrillation, and Chronic Airway Obstruction.	F 282	F282 A. With respect to the Specific Residents Cited: Resident #88 is no longer a resident of the facility, as she expired 1/9/16. The CNA#10 reported to have resigned from his position the same day on 10/30/15, refusing to sign the disciplinary action form presented by the ADON. This event was a self-report to the Dept. of Health on 10/23/15 by the Administrator and subsequently investigated by the Dept. of Health without any cited deficiency. The event where Resident #92 was allegedly being improperly fed by CNA#3 was reported to the Dept. of Health on 2/8/15 by the Administrator This event was investigated, substantiated, and the employee terminated for her actions upon completion of the investigation on 2/9/16. B. With Respect to How the Facility will Identify Residents with the Potential for the Identified Concern and Take Corrective Action: Residents have the potential to be affected by the deficient practice allegation of failure to follow facility standards regarding providing services by a qualified person and/or per the resident's plan of care.	3/19/16

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F 282	Continued From page 17 Review of the Significant Change Minimum Data Set, dated 11/18/15, revealed Resident #88 required extensive assistance of 2 staff for bed mobility, transfers, dressing and toileting. Review of the facility Standing Orders, no date, revealed "...Hemorrhoid pain: ...name brand (Hydrocortisone) or suppository every 6 hours PRN [as needed]..." Review of a Record of Counseling, dated 10/30/16, revealed "... [CNA name]...Practicing outside scope of practice (Administering medication to a resident)..." Review of the, Witness Statement Report signed and dated 10/23/15, by CNA #10 confirmed he had applied hemorrhoid cream to Resident #88. Telephone interview with CNA #10 on 2/22/16 at 5:20 PM, in the conference room, confirmed he had applied the hemorrhoid cream to the resident. Interview with the Assistant Director of Nursing on 2/22/16 at 2:50 PM, in the conference room, confirmed the facility had failed to ensure the medications were being administered by a qualified person. Medical record review revealed Resident #92 was admitted to the facility on 11/5/13, with diagnoses including Dementia, Anxiety, Seizures, Depressive Disorder, and Dysphagia (difficulty swallowing). Medical record review of the quarterly Minimum Data Set dated 1/24/16, revealed Resident #92 had a Brief Interview of Mental Status (BIMS)	F 282	A general audit of care delivery practices by aides which included observation of incontinence care and assisted feeding practices was done by DON/Nurse Educator on 10/23/15 and 2/8/16. No other issues were identified. **C. With Respect to What Systemic Measures have been put in place to address the Stated Concern.** On 10/23/15 the DON/designee re-educated nursing staff, including CNAs and LPNs regarding practicing within their scope of practice, including application of creams when ordered by the physician. By 03/16/16, licensed staff and CNAs were re-educated by the Nurse Educator (NE) on practicing within their scope of practice, including application of creams when ordered by licensed staff only and providing care services per the resident's plan of care, including allowing adequate eating time. Newly hired staff receives education on practicing within their scope of practice, including application of creams when ordered by the physician during the orientation process and at least annually. By 03/16/16, Department Managers (DM) were re-educated by the NE regarding observing and reporting any concerns of aides providing care outside their scope of practice and/or not providing care as specified in the care plan, including allowing adequate eating time. The DM's will observe practices	

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F 282	Continued From page 18 score of 2 indicating the resident was severely cognitively impaired and required the total assistance of staff members for all activities of daily living. Medical record review of Resident #92's care plan dated 11/21/13, and last reviewed on 1/29/16, revealed "...has nutritional problem r/t Diet restrictions...The resident needs a calm, quiet setting at meal times with adequate eating time..." Review of a facility investigation incident report dated 2/16/16, revealed on 2/7/16, CNA #3 was feeding Resident #92 her breakfast and LPN #1 was present in the room. Continued review of the facility investigation revealed Resident #92's daughter was standing outside of the resident's room listening to what CNA #3 was saying to her mother. Continued review of the investigation revealed both LPN #1 and the daughter heard Resident #92 tell CNA #3 "no" when offered another bite of food but CNA #3 continued to spoon food into the resident's mouth. Interview with the Administrator and the ADON on 2/19/16, at 4:20 PM, in the Administrator's office, confirmed Resident #92 was not fed her breakfast on 2/7/16 with adequate eating time as her care plan stated.	F 282	during their daily rounds using the Survey Preparedness form and report any issues during the daily standup and stand down meetings. Any negative findings will be immediately addressed by the DON/designee. Audits will be conducted 5 times per week for 12 weeks, then randomly thereafter. D. With Respect to How the Plan of Corrective Measures will be monitored: The facility Administrator (ADM) reviews the results of the audits in conjunction with the QAPI committee. Any aberrancy reported has interventions developed and appropriate actions taken by the ADM in conjunction with the QAPI Committee. When current interventions are not producing the desired outcome or resolution to prior issues, the ADM in conjunction with the QAPI committee will develop alternate interventions until compliance is achieved.	
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	F371 A. With respect to the Specific Residents Cited: The perforated-packaged, pureed shaped food was discarded by the Certified Dietary Manager (CDM). Pureed foods were placed in a 4-6 in deep 1 /2 pans and placed directly on	3/19/16

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F 371	Continued From page 19 This REQUIREMENT is not met as evidenced by: Based on review of manufacture's directions, observation, and interview, the facility failed to provide food at appropriate temperatures for 20 of 20 residents being served a pureed pork product, and failed to restrain hair while preparing and serving food for 117 residents. The findings included: Review of the manufacturer's directions for Pureed Shaped, Roast Pork revealed "...Steamer: Use perforated tear to portion desired number of servings from tray. Place frozen tray of meat (film side up) in perforated steam table pan. Steam 165 degrees F (20-30 minutes). Cooking times will vary depending on the steamer load and pressure. After cooking product, place tray film side down and allow to stand for 3-5 minutes. Remove film, turn tray upside down and push lightly on the bottom of each portion to release...." Observation on 2/16/16 at 11:35 AM, in the facility kitchen with the Certified Dietary Manager (CDM), revealed approximately 20 residents were to be served pureed premade pork. Continued observation revealed the CDM calibrated a thermometer to 32 degrees Fahrenheit (F), pulled 1 package of the pureed premade pork out of the steam oven, set the package on the table and inserted the thermometer, into the meat and obtained a reading of 120 degrees. Continued	F 371	the steam table by the CDM. The temperatures found on the day of the survey 2/16/16, were corrected by heating the food to the proper temperature before serving by the CDM. The plates that had been dipped were pulled and heated to proper temp. by the CDM. The lunch trays were pulled and heated to proper temperature and the remaining pureed food was heated to proper temp prior to serving by the CDM. On the day of the survey 2/17/16, Dietary Staff members without proper hair nets were instructed to leave the line, apply net per facility standards, wash hands and return to the serving line by the CDM. **B. With Respect to How the Facility will Identify Residents with the Potential for the Identified Concern and Take Corrective Action:** Residents have the potential to be affected by the deficient practice allegation of failure to follow facility policy regarding sanitary conditions of food. The perforated-packaged, pureed shaped food is no longer in use. Pureed foods will be prepared by the dietary staff. Pureed foods are to be pureed and placed in a 4-6 in deep 1 /2 pans and placed directly on the steam table by the Cook. An audit of sanitary food service was done by the Certified Dietary Manager (CDM), using a "Sanitation Survey" audit of the food service areas within the facility on 2/17/16 and any concerns were addressed as appropriate by the CDM. **C. With Respect to What Systemic Measures have been put in place to address the Stated Concern.** A monitoring form developed by the CDM Check List", has been put into place for the food temp specific for pureed foods and making sure the cooks have done them prior to, during servicing time if needed and at the end if there is enough food to measure temperature. The CDM will audit these	

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F 371	Continued From page 20 observation revealed the CDM pulled another package of premade pureed pork out from the steam oven, set the package on the table, inserted the thermometer into the meat, and again obtained a 120 degrees F reading. Interview with the CDM at that time confirmed the 120 degree F reading was "too low", and not the 165 degrees required by the manufacturer. Observation on 2/16/16, at 11:35 AM, in the facility kitchen revealed Cook #1 was preparing and serving food on the tray line, had a hair net on her head, with her bangs and hair on her left side hanging out of the hair net. Observation on 2/17/17, at 4:55 PM in the facility kitchen revealed Cook #2 was serving food on the tray line, had a hairnet on her head, with her bangs and the hair on her collar hanging out of the hair net. Interview with the CDM on 2/17/16, at 5:05 PM, in the kitchen the CDM confirmed, the facility failed to ensure dietary staff had their hair restrained when preparing and serving food for the residents. Observation on 2/17/16 at 5:00 PM, with the CDM in the facility kitchen revealed, 10 trays were prepared for residents with pureed premade pork. Continued observation revealed the dietary staff had the pureed premade pork, in unperforated steam table pans, sitting on a counter top. Continued observation with the CDM revealed the CDM again calibrated the thermometer to 32 degrees F. Continued observation revealed the CDM pulled 1 package of the pureed premade pork from the steam table pan, set it on the table, inserted the thermometer into the meat and obtained a reading of 142 degrees.	F 371	tools daily and address any concerns immediately as indicated. On 2/24/16, Dietary staff, including Cooks #1 and #2, and Cook-helpers, was re-educated by the CDM on facility policies regarding safe sanitary conditions, pureed food preparation, proper food temperatures as well as proper covering of facial hair in all kitchen food preparation and food serving areas and on the proper way to calibrate a thermometer and how to take temps and to document their findings. The Administrator re-educated the CDM on facility policies regarding safe sanitary conditions on 2/24/16. The CDM/designee will conduct weekly "Sanitation Survey" audits and document any issues and place requirements for correction into the TELS system for resolution by the maintenance, housekeeping or kitchen staff. This audit will include observations of dietary employees to verify those working in the kitchen and food service areas have a hair restraint on and that all hair is covered. **D. With Respect to How the Plan of Corrective Measures will be monitored:** The CDM or Dietitian will monitor audits regarding sanitary food service monthly and report findings at monthly QAPI. Facility Administrator or designee will conduct random audits of sanitary food service and report findings at monthly QAPI meeting. The ADM reviews the results of the audit in conjunction with the QAPI committee. Any aberrancy reported has interventions developed and appropriate actions taken by the	

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F 371	Continued From page 21 Interview with the CDM on 2/17/16 at 5:00 PM, in the facility kitchen, confirmed the pork was" not hot enough", the 142 degree F reading was "too low", and not the 165 degrees required by the manufacturer.	F 371	ADM/DSM in conjunction with the QAPI Committee. When current interventions are not producing the desired outcome or resolution to prior issues, the ADM/DON in conjunction with the QAPI committee will develop alternate interventions until compliance s achieved.	
F 431 SS=F	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can	F 431	F431 A. With respect to the Specific Residents Cited: The expired vials, ports, collection tubes, pre-filled syringes, tube feeding supplies and medications cited was discarded by the charge nurse and unit managers at the time of survey 2/19/16 from the medication room, and all medication carts. No resident was affected. B. With Respect to How the Facility will Identify Residents with the Potential for the Identified Concern and Take Corrective Action: Residents receiving medications have the potential to be affected by the deficient practice allegation of failure to follow facility policy regarding medication storage and administration. Audits of all medication carts for expiration dates were performed by the DON/designee through 2/19/16. Any expired medications found were immediately discarded by the DON/designee.	3/19/16

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F 431	Continued From page 22 be readily detected. This REQUIREMENT is not met as evidenced by: Based on review of facility policy, observation and interview, the facility failed to maintain 1 of 1 medication storage room, and 3 of 4 medication carts to ensure expired medications and medication-related supplies were disposed of properly, and failed to store a medication at the proper temperature. The findings included: Review of the facility policy, Medication Storage in the Facility, dated August 2012 revealed, "...Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal (see Section IE: Disposal of Medications and medication-related supplies), and reorder from the pharmacy..." Continued review of the policy, revealed "...Medications requiring 'refrigeration' or 'temperatures between 2 degrees Celsius (36 degrees Fahrenheit) and 8 degrees Celsius (46 degrees Fahrenheit)' are kept in a refrigerator with a thermometer to allow temperature monitoring. Medications requiring storage 'in a cool place' are refrigerated unless otherwise directed on the label..." Observation with Registered Nurse (RN) # 2, on 2/19/16 at 9:20 AM, in the Medication Select Room, revealed 4 Y-Port connectors (used for tube feeding) dated 12/2015 (expired), 12 blood	F 431	C. With Respect to What Systemic Measures have been put in place to address the Stated Concern. By 03/16/16, facility nurses, including LPNs, including LPN#2, #3, and #4, and RNs, including RN#2, were educated by the NE/designee on the importance of checking the expiration dates on all medications, collection tubes, pre-filled syringes, tube feeding supplies, vials and ports at least twice prior to use. The education included discussions on the proper storage of medications, including those medications requiring refrigeration. Newly hired nurses receives education on the importance of checking the expiration dates on all medications, collection tubes, pre-filled syringes, tube feeding supplies, vials and ports at least twice prior to use through the orientation process and are re-educated at least annually by the Nurse Educator. The DON/designee will inspect medication carts for expired products weekly for 12 weeks and will also review expired medication compliance audits each weekday using a "Quality Assurance Review Audit" form for 4 weeks, then weekly times one month. Pharmacy Consultant or designee will monitor monthly thru monthly med pass reviews and evaluate medication carts for outdated medications and report findings at monthly QAPI meeting. Issues will be immediately addressed and corrected as necessary.	

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F 431	Continued From page 23 collection tubes dated 12/2015 (expired), 2 120 ounce containers of sterile water dated 2/2015 and 10/2015 (expired), and 25 Heparin Flush pre-filled syringes dated 9/2015 (expired). Interview with RN #2, on 2/19/16 at 9:40 AM, in the medication storage room, confirmed all the items were expired and should have been disposed of. Observation with Licensed Practical Nurse (LPN) #3, on 2/19/16 at 9:45 AM, on the 200 hallway, revealed an opened bottle of Dorzolamide-Timolol eye drops stored on the medication cart with an expiration date of 1/26/16. Interview with LPN #3, on 2/19/16 at 9:45 AM, in the 200 hallway, confirmed the medication was expired and available for resident use. Observation with LPN #4, on 2/19/16 at 10:00 AM, on the 100 hallway, revealed an opened bottle of Vitamin B-6 tablets stored on the medication cart with an expiration date of 9/15. Interview with LPN #4, on 2/19/16 at 10:05 AM, on the 100 hallway, confirmed the medication was expired and available for resident use. Observation with LPN #2, on 2/19/16 at 10:15 AM, on the 400 hallway, revealed an opened bottle of acidophilus with pectin stored on the medication cart, with storage recommendation to refrigerate and with an expiration date of 12/25/15 Interview with LPN #2, on 2/19/16 at 10:20 AM, on the 400 hallway, confirmed the medication should have been refrigerated, was expired and was available for resident use.	F 431	D. With Respect to How the Plan of Corrective Measures will be monitored: DON or designee will review all audits and report findings at monthly QAPI meeting for resolution. The ADM/DON reviews the results of the audit in conjunction with the QAPI committee or designated subcommittee. Any aberrancy reported has interventions developed and appropriate actions taken by the ADM/DON in conjunction with the QAPI Committee. When current interventions are not producing the desired outcome or resolution to prior issues, the ADM/DON in conjunction with the QAPI committee will develop alternate interventions until compliance is achieved.	

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F 431	Continued From page 24 Interview with the Director of Nursing (DON), on 2/22/16 at 5:00 PM, in the 100 hallway, confirmed the facility failed to ensure the policy for medication storage in the facility was being followed.	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.	F 441	F441 A. With respect to the Specific Residents Cited: The facility will maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. All residents receiving in-house glucose monitoring were assessed by the DON/designee on 2/17/16 and no negative findings were identified. Glucometers were observed to be cleaned and disinfected between each resident use during the DON/designee assessment of all other residents on 2/17/16 for the clinical staff working. LPN #5 was re-educated regarding prevention of cross-contamination and infection control on the day of the survey 2/17/16 by the NE/designee. By 03/16/16, facility nurses were re-educated by the Nurse Educator/designee on general Infection Control (IC) practices, including the proper cleansing of glucometers prior to use and proper hand washing prior to blood glucose check. The NE/designee will observe Infection Control practices of staff weekdays, and Weekend Manager will observe on weekends and	3/19/16

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F 441	Continued From page 25 (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on review of facility policy, observation and interview, the facility failed to ensure prevention of cross contamination during the use of 1of 4 glucometers (a device used to monitor the level of glucose in the blood) observed. The findings included Review of the facility policy, Microdot Blood Glucose Meter, dated 2011, revealed "The Microdot blood glucose meter (glucometer) is cleaned and disinfected between each resident test..." Observation with Licensed Practical Nurse (LPN) #5 during the medication pass, on 2/17/16 at 8:30 AM, on the 100 hallway, revealed the nurse removed the glucometer out of the medication cart, took it into the resident room, placed it on the bed, obtained the blood glucose level, disposed of the used items, and returned the glucometer to the medication cart drawer without cleaning the glucometer. Interview with LPN #5 on 2/17/16 at 8:35 AM, in the 100 hallway revealed "... we clean them if they are visibly soiled...not sure what policy says if they are to be cleaned between resident use..."	F 441	document issues using a "Quality Assurance Review Audit" form for 12 weeks. **B. With Respect to How the Facility will Identify Residents with the Potential for the Identified Concern and Take Corrective Action:** All residents have the potential to be affected by the deficient practice allegation of failure to follow facility policy regarding Infection Control (IC) practices including those receiving blood glucose monitoring. All facility blood glucose monitors were properly cleaned per facility policy on 2/17/16 by nursing staff. An observation audit of facility Infection Control practices was done through 03/16/16 by the DON and NE/designee. Any issues identified were corrected at the time of identification **C. With Respect to What Systemic Measures have been put in place to address the Stated Concern.** By 03/16/16, facility nurses, including LPN#5, were re-educated by the Nurse Educator/designee on general Infection Control (IC) practices, including the proper cleansing of glucometers prior to use and proper hand washing prior to blood glucose check. The NE/designee will observe Infection Control practices of staff weekdays, and Weekend Manager will observe on weekends and document issues using a "Quality Assurance Review Audit" form for 12 weeks. The DON or designee will review	

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F 441	Continued From page 26 Interview with the Assistant Director of Nursing on 2/18/16 at 1:55 PM, in the conference room, confirmed the facility failed to follow the policy for the cleaning of the glucometer.	F 441	all audits and report findings at monthly QAPI meeting. Issues will be immediately addressed and corrected as necessary. D. With Respect to How the Plan of Corrective Measures will be monitored:	
F 502 SS=D	483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to obtain labs as ordered by the physician for 2 residents (#77, #39,) of 5 residents reviewed for unnecessary medications of 35 sampled residents. The findings included: Review of facility policy, Laboratory Procedures/Other Diagnostic Services, Revised 2010, revealed, "...all laboratory services are provided upon the order of the resident's attending physician or a consultant physician as authorized by the attending physician. The attending physician will be notified of the findings of all laboratory tests..." Medical record review revealed Resident #77 was admitted to the facility on 7/7/14, with diagnoses including Above the Knee Amputation, Peripheral Vascular Disease, Bipolar Disorder, Anorexia, Type 2 Diabetes Mellitus with Neuropathy, and Alzheimer's Dementia.	F 502	DON or designee will review all audits and report findings at monthly QAPI meeting for resolution. The ADM/DON reviews the results of the audit in conjunction with the QAPI committee or designated subcommittee. Any aberrancy reported has interventions developed and appropriate actions taken by the ADM/DON in conjunction with the QAPI Committee. When current interventions are not producing the desired outcome or resolution to prior issues, the ADM/DON in conjunction with the QAPI committee will develop alternate interventions until compliance is achieved. F502 A. With respect to the Specific Residents Cited: Resident #77's labs were reordered by the physician and obtained 2/19/16; results were obtained, MD notified by the nurse, but gave no new orders. Resident #39's labs were reordered and obtained 3/1/16, results were obtained, MD notified by the nurse and no new orders were given. Both residents were assessed on 2/19/16 by the DON/designee for any adverse effects	3/19/16

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F 502	Continued From page 27 Medical record review of a Physician's telephone order dated 2/10/16, revealed "...1). D/C [discontinue] Nephrocaps-AKA [above knee amputation] healed. 2). Repeat Albumin Level..." Medical record review of Resident #77's laboratory results, revealed the Albumin level ordered by the Physician on 2/10/16 had not been obtained. Interview with the Medical Records Director on 2/18/16, at 5:55 PM, in the conference room, revealed the Albumin level the Physician ordered on 2/10/16, had been drawn but the laboratory technician lost the requisition form so the test had not been completed. Continued interview confirmed the Albumin level was not redrawn, and no systems were in place to ensure Physician's orders for laboratory tests were completed. Medical record review revealed Resident #39 was admitted to the facility on 8/2/12, with diagnoses including Chronic Kidney Disease, Edema, Hypertension, Anemia, Dementia, Atherosclerotic Disease, Peripheral Vascular Disease, Chronic Obstructive Pulmonary Disease, Mood Disorder, Major Depression and Anxiety. Medical record review of the Medication Review Report (physician recapitulation orders) dated 8/1/15 revealed a physician's order for "... BMP (Basic Metabolic Panel) and Magnesium, every 3 months is due November, February, May, August..." Medical record review revealed no laboratory reports for August 2015 and November 2015. Interview with the Medical Records	F 502	related to the alleged practice, and no adverse findings were noted. **B. With Respect to How the Facility will Identify Residents with the Potential for the Identified Concern and Take Corrective Action:** Residents receiving diagnostic services have the potential to be affected by the deficient practice allegation of failure to follow facility policy regarding physician orders. An audit was performed by the Clinical IDT on 2/19/16 of MD orders and lab results from the previous 60 days. Any issues identified were corrected at the time of identification. **C. With Respect to What Systemic Measures have been put in place to address the Stated Concern.** Lab vendor contacted prior to and on the day of the survey 2/19/16 and has updated their current system to allow for recurring labs to be scheduled. Computerized Lab System was set up to alert the staff when labs were due for up to one year; however computer glitch was not consistently pulling the data. Medical Records Nurse re-entered scheduled labs due for all residents for one year after glitch corrected, and has manual list as well which will be used to check off labs as completed. Nursing staff will conduct lab order search daily within the computer system to determine labs to be drawn and the clinical IDT will review in the weekday clinical meetings. The weekend nursing supervisor will conduct the lab order search on the weekend to ensure ordered labs are drawn. Review of	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445237	A. BUILDING _____ B. WING _____	02/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHURCH HILL CARE & REHAB CTR	701 WEST MAIN BLVD CHURCH HILL, TN 37642

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F 502	Continued From page 28 Coordinator/Licensed Practical Nurse on 2/19/16 at 11:15 AM, in the conference room, confirmed the facility failed to obtain the physician ordered lab work in August 2015 and in November 2015 for Resident #39.	F 502	appropriate lab vendor requisition will occur and scheduled labs will be drawn as ordered on daily basis by the nursing supervisor. Follow up to ensure process completed will be done by the DON/designee by auditing list of labs to be drawn each day for follow up. By 03/16/16, facility nurses were re-educated by the NE/designee on importance of following physician orders, including the requirement to review MD progress notes and lab orders after MD review and clarify and properly document lab orders per facility standards. Newly hired nurses will receive this education through the orientation process and at least annually. The DON/designee will review MD orders and medication compliance audits each weekday using a "Quality Assurance Review Audit" form for 4 weeks, then weekly times one month. Pharmacy Consultant or designee will monitor monthly and evaluate MD orders for compliance and report findings at monthly QAPI meeting. Issues will be immediately addressed and corrected as necessary. **D. With Respect to How the Plan of Corrective Measures will be monitored:** DON or designee will review all audits and report findings at monthly QAPI meeting for resolution. The ADM/DON reviews the results of the audit in conjunction with the QAPI committee or designated subcommittee. Any aberrancy reported has interventions developed and appropriate actions taken by the ADM/DON in conjunction with the QAPI Committee. When current interventions are not producing the desired outcome or resolution to prior issues, the ADM/DON in conjunction with the QAPI committee will develop alternate interventions until compliance is achieved.	